

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395830</b>	(X2) MULTIPLE CONSTRUCTION:  A. BLDG: <u>00</u> B. WING: _____		(X3) DATE SURVEY COMPLETED:  <b>04/13/2023</b>
NAME OF PROVIDER OR SUPPLIER: <b>MEADOW VIEW NURSING CENTER</b>  STATE LICENSE NUMBER: <b>191702</b>			STREET ADDRESS, CITY, STATE, ZIP CODE: <b>1404 HAY STREET BERLIN, PA 15530</b>		
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F 0000	INITIAL COMMENT	F 0000			
	Based on a Medicare/Medicaid Recertification survey, State Licensure survey, Civil Rights Compliance survey, and a complaint survey completed on April 13, 2023, it was determined that Meadow View Nursing Center was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.				
F 0641  SS=A		F 0641			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE:

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0641  SS=A	Continued from page 1  483.20(g) Accuracy of Assessments  §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.  This REQUIREMENT is not met as evidenced by:	F 0641	Resident 106's Minimum Data Set Assessment was reviewed and modified by facility Registered Nurse Assessment Coordinator on 04/13/2023. Director of Nursing/designee will complete an audit of the last thirty days of Minimum Data Set Assessment discharge assessments for accuracy. Registered Nurse Assessment Coordinator to modify as needed. Registered Nurse Assessment Coordinator will be re-educated on Minimum Data Set Assessment section 2100 of the Resident Assessment Instrument User's Manual by Clinical Reimbursement Specialist, Margaret Turner. Director of Nursing /designee will complete random weekly audits of Minimum Data Set Assessment discharge assessments x 4 weeks and monthly x 2 months. Results of audit findings will be reported to the Quality Assurance Performance Improvement Committee.	Completion Date: <b>06/07/2023</b> Status: <b>APPROVED</b> Date: <b>05/08/2023</b>	

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F 0641  SS=A	Continued from page 2  Based on review of the Resident Assessment Instrument User's Manual and clinical records, as well as staff interviews, it was determined that the facility failed to complete accurate discharge Minimum Data Set assessments for one of 42 residents reviewed (Resident 106).  Findings include:  The Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2019, revealed that Section A2100 (Discharge Status) was to be coded one (1) through eight (8) depending on the location of the resident's discharge. If the resident was discharged to the community (including a boarding home or assisted living facility) or home, then Section A2100 was to be coded one (1), and if the resident was discharged to an acute care hospital, then Section A2100 was to be coded three (3).	F 0641			

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F 0641  SS=A	Continued from page 3  Physician's orders for Resident 106, dated March 22, 2023, included an order for the resident to be discharged home with services of home health.  A nursing progress note for Resident 106, dated March 22, 2023, at 1:32 p.m. revealed that the resident's physician confirmed and verified the following order for the resident to discharge home with the services of home health. A nursing progress note at 1:52 p.m. revealed that at 1:30 p.m. the resident was discharged home with her medications and belongs and was accompanied by her daughter. Discharge instructions were given to the resident by the registered nurse.  A discharge MDS assessment for Resident 106, dated March 22, 2023, revealed that Section A2100 was coded three (3), indicating that the resident was discharged to an acute care hospital.  Interview with Registered Nurse Assessment Coordinator 1 (RNAC - a registered nurse who is	F 0641			

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F 0641  SS=A	Continued from page 4  responsible for the completion of MDS assessments) on April 13, 2023, at 4:07 p.m. confirmed that Section A2100 of Resident 106's discharge MDS assessment of March 22, 2023, was not accurate and should have been coded to indicate that the resident was discharged to the community.  28 Pa. Code 211.5(f) Clinical records	F 0641			
F 0656  SS=D		F 0656			

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F 0656  SS=D	Continued from page 5  483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan  §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future	F 0656	Resident 62's care plan was updated on 04/11/2023 to include anticoagulant medications. Director of Nursing /designee will complete an audit of current residents with anticoagulant orders for accuracy of care plans. Director of Nursing /designee will re-educate licensed staff and interdisciplinary team on developing and updating resident's care plans. Director of Nursing /designee will complete random audits of residents on anticoagulants for care plan accuracy weekly x 4 weeks and monthly x 2 months. Results of audit findings will be reported to the Quality Assurance Performance Improvement Committee.	Completion Date: <b>06/07/2023</b> Status: <b>APPROVED</b> Date: <b>05/08/2023</b>	

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F 0658  SS=D	Continued from page 7  483.21(b)(3)(i) Services Provided Meet Professional Standards  §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality.  This REQUIREMENT is not met as evidenced by:	F 0658	Resident 65 physician notified and no ill effects of low blood sugar Director of Nursing /designee will complete a review of current resident progress notes for the past 14 days for change in condition requiring professional (registered) nurse assessment. Director of Nursing /designee will re-educate professional registered nurses on change in condition. Director of Nursing /designee will complete audits verifying professional nurse assessment and documentation weekly x 4 weeks and monthly x 2 months. Results of audit findings will be reported to the Quality Assurance Performance Improvement Committee.	Completion Date: <b>06/07/2023</b> Status: <b>APPROVED</b> Date: <b>05/08/2023</b>	

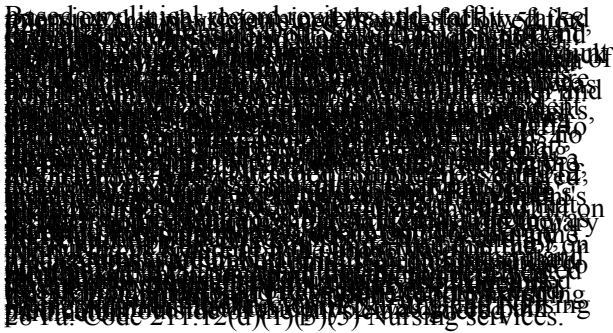
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F 0658  SS=D	<p>Continued from page 8</p> <p>Based on review of the Pennsylvania Nurse Practice Act and residents' clinical records, as well as staff interviews, it was determined that the facility failed to ensure that a professional (registered) nurse completed an assessment of a resident following a change in condition for one of 42 residents reviewed (Resident 65).</p> <p>Findings include:</p> <p>The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.11 (a)(1)(2)(4) indicated that the registered nurse was to collect complete and ongoing data to determine nursing care needs, analyze the health status of individuals and compare the data with the norm when determining nursing care needs, and carry out nursing care actions that promote, maintain and restore the well-being of individuals.</p> <p>A quarterly Minimum Data Set (MDS) assessment (a federally-mandated assessment of a resident's</p>	F 0658			

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F 0658  SS=D	<p>Continued from page 9</p> <p>abilities and care needs) for Resident 65, dated January 31, 2023, revealed that the resident was understood and could understand, required limited to extensive assistance from staff for his daily care tasks, and had diagnoses that included diabetes.</p> <p>A nursing note for Resident 65, completed by the licensed practical nurse, dated November 18, 2022, at 3:18 a.m. revealed that the resident's evening blood sugar was 55 milligrams/deciliter (mg/dL) (a normal blood sugar level is between 70 to 100 mg/dL). The resident was nonresponsive, and the registered nurse was notified. The resident was administered one milligram (mg) of Glucagon (a hormone that raises blood glucose levels). A recheck of the resident's blood sugar level 10 minutes after the injection of Glucagon was 89 mg/dL. The resident was responding per usual and was given orange juice and peanut butter crackers. The resident's evening insulin was held.</p> <p>There was no documented evidence that Resident 65 was assessed by a professional (registered)</p>	F 0658			

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F 0658  SS=D	Continued from page 10  nurse following this change in his condition.  Interview with Registered Nurse 2 on April 13, 2023, at 11:21 a.m. revealed that a professional (registered) nurse should have assessed the resident and written a note.  Interview with the Director of Nursing on April 13, 2023, at 1:18 p.m. confirmed that there was no documented evidence that a professional (registered) nurse assessed Resident 65 following this change in his condition.  28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.	F 0658			
F 0684  SS=E		F 0684			

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F 0684  SS=E	Continued from page 11  483.25 Quality of Care  § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.  This REQUIREMENT is not met as evidenced by:	F 0684	Resident 51's blood sugar results from February 21, March 23, March 31, and April 9, 2023 were reviewed with physician. Residents 54 and 58 urinary outputs for last 30 days reviewed with physician. Resident 62 pain assessment completed. Pain medications reviewed with physician Director of Nursing /designee will complete an audit of residents with sliding scale insulin coverage from past 30 days for verification of physician notification of results outside of parameters. Physician to be notified as appropriate. Director of Nursing/designee will complete an audit of current residents who received prn pain medication in the past 30 days to verify administered in accordance with pain scale. Current residents with orders for Foley catheter outputs will be reviewed for documentation of urinary output for past 30 days. Director of Nursing /designee will re-educate licensed staff on following physician's orders	Completion Date: <b>06/07/2023</b> Status: <b>APPROVED</b> Date: <b>05/08/2023</b>	

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F 0684  SS=E	Continued from page 12	F 0684	including parameter notification, documentation of urinary output, and pain medication parameters Director of Nursing /designee will complete audit of sliding scale insulin parameters weekly x 4 weeks and monthly x 2 months. Physician will be notified as needed. Director of Nursing/ designee will complete audit of pain medication administration and parameters weekly x 4 weeks and monthly x 2 months. Physician will be notified as needed Director of Nursing / designee will complete audit of Foley catheter outputs weekly x 4 weeks then monthly x 2 months. Physician will be notified as needed Results of audit findings will be reported to the Quality Assurance Performance Improvement Committee.		

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F 0684  SS=E	Continued from page 13  	F 0684			
F 0689  SS=E		F 0689			

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F 0689  SS=E	Continued from page 14  483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices  §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and  §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by:	F 0689	Resident 94's medical record and incident reports reviewed by Director of Nursing /designee for care plan interventions. Director of Nursing /designee will review incident reports for the month of April for documented appropriate interventions. Director of Nursing /designee will re-educate licensed staff on implementing and documenting interventions after falls. Director of Nursing /designee will complete random audits of incident reports to verify interventions implemented weekly x 4 and monthly x 2 and report audit findings to the monthly Quality Assurance Performance Improvement Committee.  Resident 27 leg rests were applied to wheelchair when identified on 04/12/2023. Residents in wheelchairs were assessed for appropriate use of leg rests by rehabilitation director/designee. Facility Staff will be re-educated on	Completion Date: <b>06/07/2023</b> Status: <b>APPROVED</b> Date: <b>05/08/2023</b>	

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F 0689  SS=E	Continued from page 15	F 0689	applying leg rests when transporting residents by Director of Nursing /designee. Director of Nursing /designee will complete visual random weekly audits x 4 weeks and monthly x 2 of leg rests while being transported and report audit findings to the monthly Quality Assurance Performance Improvement Committee for further recommendations x 2 months.		

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F 0689  SS=E	<p>Continued from page 16</p> <p>Based on a review of facility policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that residents received assistance devices to prevent accidents for one of 42 residents reviewed (Resident 27) and failed to develop and implement new interventions for fall/injury prevention for one of 42 residents reviewed (Resident 94).</p> <p>Findings include:</p> <p>The facility's policy for transporting residents via wheelchair, dated April 11, 2023, revealed that residents will not be transported (pushed) in wheelchairs without the use of leg rests.</p> <p>The facility's policy for fall reduction and interventions, dated April 11, 2022, revealed that an individualized plan of care is developed for those identified at risk, with interventions implemented to reduce the risk of falls and minimize potential injury. After every fall, attempts are made to identify a</p>	F 0689			

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F 0689  SS=E	Continued from page 17  possible root cause for the fall and implement additional or revised interventions that are relevant to the fall. If underlying causes cannot be readily identified or corrected, staff will attempt various interventions, based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable. In conjunction with the attending physician, staff will identify and implement relevant interventions (e.g., hip padding or treatment of osteoporosis, as applicable) to try to minimize serious consequences of falling. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician will help the staff reconsider possible causes that may not previously have been identified  A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 27, dated February 9, 2023, revealed that the resident was cognitively	F 0689			

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F 0689  SS=E	Continued from page 18  intact, required limited assistance for daily care needs including transfers and locomotion on and off the unit, and had diagnoses that included heart failure.  Physician's orders for Resident 27, dated April 11, 2023, included that the resident was to use a standard wheelchair with leg rests and a pressure-relieving cushion.  A care plan for Resident 27 for being at risk of complications due to a dependence for activities of daily living included an intervention, dated April 11, 2022, that the resident was to use a standard wheelchair with leg rests and a pressure-relieving cushion.  Observation of Resident 27 on April 12, 2023, at 2:05 p.m. revealed that the resident was sitting in a wheelchair and was being transported through the hallway to her room by Licensed Practical Nurse 1. There were no footrests on her wheelchair to prevent her feet from dragging during the transport.	F 0689			

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F 0689  SS=E	<p>Continued from page 19</p> <p>An interview with Licensed Practical Nurse 1 at that time confirmed that the resident should have had leg rests on her wheelchair to prevent injury during the transport.</p> <p>An interview with the Director of Nursing on April 12, 2023, at 3:30 p.m. confirmed that footrests should have been used when transporting Resident 27 in her wheelchair.</p> <p>An annual MDS assessment for Resident 94, dated February 23, 2023, revealed that the resident was usually understood and could usually understand others, required extensive assistance with personal hygiene needs, ambulated with one-person physical assist, and had a diagnosis of Alzheimer's disease.</p> <p>A nurse's note for Resident 94, dated March 10, 2023, at 2:49 p.m. revealed that the resident was found lying on his back on the floor in front of the doorway to his room. There was no documented evidence that an intervention was implemented to</p>	F 0689			

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F 0689  SS=E	Continued from page 20  attempt to prevent further falls or to try to minimize consequences of falling after this fall.  A nurse's note for Resident 94, dated March 25, 2023, at 5:46 a.m. revealed that the resident was ambulating in his room without assistance and sustained a fall. The resident reported he was getting up to get help and that he had lower back pain prior to the fall. There was no documented evidence that an intervention was implemented to attempt to prevent further falls or to try to minimize consequences of falling after this fall.  A nurse's note for Resident 94, dated April 6, 2023, at 11:07 p.m. revealed that the resident was witnessed standing up beside his wheelchair, losing his balance and falling. There was no documented evidence that an intervention was implemented to attempt to prevent further falls or to try to minimize consequences of falling after this fall.  A care plan for Resident 94, dated March 26, 2023, revealed that no new interventions were put in	F 0689			

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F 0689  SS=E	Continued from page 21  place to prevent falls since March 10, 2022.  Interview with the Director of Nursing on April 13, 2023, at 1:22 p.m. revealed that Resident 94 is non-compliant with care and that they do the same interventions after his falls, which includes education and therapy consults, and confirmed that new interventions were not implemented and added to the resident's care plan after the falls mentioned above.  28 Pa. Code 211.10(c)(d) Resident care policies.  28 Pa. Code 211.12(d)(5) Nursing services.	F 0689			
F 0690  SS=E		F 0690			

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F 0690  SS=E	Continued from page 22  483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI  §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.  §483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.  §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.	F 0690	Resident 54's chart was reviewed and physician notified on 04/11/2023 of urology consult and recommendations, care plan reviewed and revised Resident 58 had Registered Nurse assessment, has had no ill effects. Director of Nursing /designee will complete an audit of current residents with foley catheter to verify catheter care completion. Residents that may have discrepancies will be assessed by a Registered Nurse and physician notification of assessment findings. Director of Nursing / designee will review last 30 days of consults for completion of recommendations and orders Director of Nursing /designee will re-educate nursing staff on catheter care and licensed nursing staff on follow up to consults and recommendations with attending physician. Director of Nursing /designee will complete random audits of foley catheter care and consults weekly x 4 and monthly x 2. Audit findings will	Completion Date: <b>06/07/2023</b> Status: <b>APPROVED</b> Date: <b>05/08/2023</b>	

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F 0690  SS=E	Continued from page 23  This REQUIREMENT is not met as evidenced by:		F 0690	be reviewed monthly Quality Assurance Performance Improvement Committee for further recommendations x 2 months.	

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F 0690  SS=E	<p>Continued from page 24</p> <p>Based on review of clinical records, as well as resident and staff interviews, it was determined that the facility failed to ensure that an indwelling catheter change was completed as recommended by the urologist for one of 42 residents reviewed (Resident 54) and failed to ensure that residents received proper care for indwelling urinary catheters for one of 42 residents reviewed (Resident 58).</p> <p>Findings include:</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 54, dated February 27, 2023, revealed that the resident was understood, understands, required limited assistance from staff for his daily care tasks, and has an indwelling urinary catheter (a catheter which is inserted into the bladder to drain urine).</p> <p>A urology consultation (branch of medicine that focuses on the urinary tract system) for Resident 54,</p>	F 0690			

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F 0690  SS=E	Continued from page 25  dated January 30, 2023, revealed that the resident was there for a foley change and his bladder biopsy (a procedure in which small pieces of tissue are removed from the bladder) results. The plan for the resident was to regularly change his indwelling urinary catheter in the nursing home every four weeks and in six months schedule a visit with us for evaluation and to change his indwelling urinary catheter. The nursing home was to get in touch with them if there were any problems with the resident. The resident was agreeable to all the above.  However, there was no documented evidence in Resident 54's clinical record that the resident's physician was notified of the urologist's recommendations until April 11, 2023, or that the resident's indwelling urinary catheter was changed four weeks after the January 30, 2023, consultation.  Physician's orders for Resident 54, dated April 11, 2023, included an order for the resident to have his indwelling urinary catheter changed every four weeks during the dayshift and if there were any	F 0690			

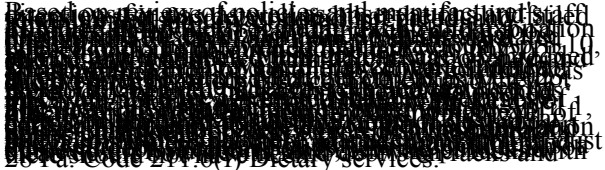
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F 0690  SS=E	<p>Continued from page 26</p> <p>issues with the resident's indwelling urinary catheter change, staff was to notify urology.</p> <p>Interview with the Director of Nursing on April 12, 2023, at 8:51 a.m. confirmed that Resident 54's physician was not notified until April 11, 2023, regarding the urologist recommendations from January 30, 2023, or that his indwelling urinary catheter was not changed as ordered four weeks after the January 30, 2023, consult.</p> <p>A quarterly MDS assessment for Resident 58, dated March 10, 2023, revealed that the resident was understood and could understand, required extensive assistance from staff for her daily care tasks, and had an indwelling catheter. The resident's care plan, dated January 26, 2021, revealed that the resident had an indwelling urinary catheter and catheter care was to be provided with morning and evening care and as needed daily.</p> <p>Review of Resident 58's clinical record, dated</p>	F 0690			

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F 0690  SS=E	Continued from page 27  January, February, and March 2023, revealed that there was no documented evidence that staff performed indwelling urinary catheter care during the dayshift on January 11, 27, and 29, 2023; February 13, 2023; and March 1, 2023.  Review of Resident 58's clinical record, dated January and February 2023, revealed that there was no documented evidence that staff performed indwelling urinary catheter care during the evening shift on January 4, 2023, and February 28, 2023.  Interview with the Nursing Home Administrator on April 12, 2023, at 3:15 p.m. confirmed that the indwelling urinary catheter care for Resident 58's was not completed as care planned on the above dates.  28 Pa. Code 211.12(d)(3)(5) Nursing services.	F 0690			
F 0804  SS=E		F 0804			

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F 0804  SS=E	Continued from page 28  483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp  §483.60(d) Food and drink Each resident receives and the facility provides-  §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;  §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature.  This REQUIREMENT is not met as evidenced by:	F 0804	Starting 4/13/2023, the Director of Dining Services began providing re-education to dietary staff members responsible for preparation of food and staff members responsible for serving food. Re-education provided included the process of ensuring that the meal cart is prepared for delivery to the individual dining areas. Team members responsible for monitoring food temperatures received re-education regarding the correct food temperatures for both cold and hot foods. This re-education included: * Cook will check food temperatures prior to putting food in steam table. * Cook will recheck the food temperatures before service * No food item can be served unless it is at the correct temperature  Director of Nursing/Designee will re- educate nursing staff on timely service of Resident Meal Pass policy.  The dietary manager /designee will audit test trays on the nursing units	Completion Date: <b>06/07/2023</b> Status: <b>APPROVED</b> Date: <b>05/08/2023</b>	

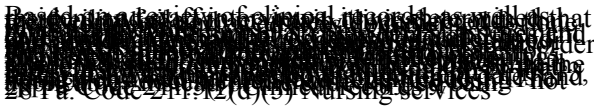
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F 0812  SS=E	Continued from page 30  483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary  §483.60(i) Food safety requirements. The facility must -  §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.  §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.  This REQUIREMENT is not met as evidenced by:	F 0812	Undated lettuce, cupcakes, macaroni noodles were removed by director of dining services and discarded. All food carts, and the metal rack was cleaned and sanitized. Floor behind ovens was swept and mopped. Cereal bowls, serving pans, and knives were re-washed. All dish washer racks were checked for food debris and cleaned.  The director of dining services made cleaning lists, so that all items identified will be cleaned and sanitized on a regular basis. All dining services staff will be educated on the importance of cleaning and sanitizing of kitchen items according to our policy and procedure manual by the Dietary manager. The director of dining services or designee will complete audit 3 times a week for 4 weeks then monthly x 2 to make sure all kitchen equipment will be cleaned and sanitized as per the policy. The director of dining services or	Completion Date: <b>06/07/2023</b> Status: <b>APPROVED</b> Date: <b>05/08/2023</b>	

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F 0812  SS=E	Continued from page 31  	F 0812	designee will complete audit of storage areas 3 times a week x 4 weeks then monthly x 2 to ensure open items are dated.		
F 0842  SS=D		F 0842			

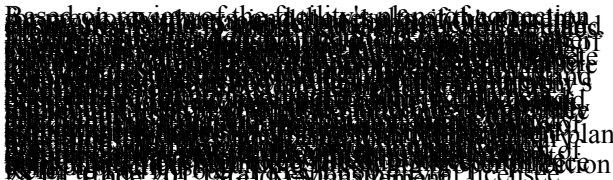
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395830</b>	(X2) MULTIPLE CONSTRUCTION:  A. BLDG: <u>00</u> B. WING: _____		(X3) DATE SURVEY COMPLETED:  <b>04/13/2023</b>
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F 0842  SS=D	Continued from page 32  483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information  §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.  §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized  §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;	F 0842	Resident 53 was offered shower/tub bath as scheduled and documentation completed. Director of Nursing /designee will complete audit of current residents shower schedules to verify showers offered and documented. Director of Nursing /designee will re-educate nursing staff on appropriately documenting showers/tub bath refusals. Director of Nursing /designee will complete random weekly audits of showers/tub bath documentation weekly x 4 weeks and monthly x 2 and report audit findings to the monthly Quality Assurance Performance Improvement Committee for further recommendations x 2 months.	Completion Date: <b>06/07/2023</b> Status: <b>APPROVED</b> Date: <b>05/08/2023</b>	

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F 0842  SS=D	Continued from page 33  (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.  §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.  §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law.  §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.	F 0842			

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F 0842  SS=D	Continued from page 34  This REQUIREMENT is not met as evidenced by:   2814 a. Code 241.12(c)(5) Nursing Services & Hold.	F 0842			
F 0867  SS=E	483.75(c)(d)(e)(g)(2)(i)(ii) QAPI/QAA Improvement Activities  §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:  §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.  §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor	F 0867	A Quality Assurance meeting was held reviewing F641, F689, F812, F880. The facility department managers and Quality Assurance Performance Improvement Committee will be educated by regional support staff on the function, purpose of the Quality Assurance Performance Improvement Committee. Random audits of these Ftags will be reviewed quarterly x 2 for compliance. The Quality Assurance Performance Improvement meeting will be conducted monthly, and findings reviewed.	Completion Date: <b>06/07/2023</b> Status: <b>APPROVED</b> Date: <b>05/08/2023</b>	

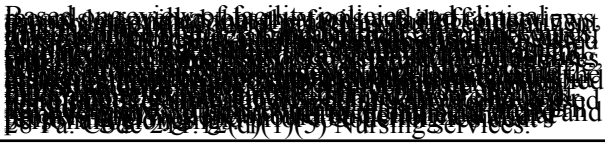
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F 0867  SS=E	Continued from page 35  performance indicators.  §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.  §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.  §483.75(d) Program systematic analysis and systemic action.  §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.  §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its	F 0867			

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F 0867  SS=E	Continued from page 36  performance improvement activities to ensure that improvements are sustained.  §483.75(e) Program activities.  §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.  §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.  §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.	F 0867			

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F 0867  SS=E	Continued from page 37  §483.75(g) Quality assessment and assurance.  §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:  (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.  This REQUIREMENT is not met as evidenced by:   Based on review of the facility's quality improvement plan, the facility's governing body did not meet the requirements of the facility's governing body to plan and implement the quality improvement plan. 281a: Code 201.18(e)(4) Management, licensee.	F 0867			

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F 0880  SS=D	<p>483.80(a)(1)(2)(4)(e)(f) Infection Prevention &amp; Control</p> <p>§483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</p> <p>§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident;</p>	F 0880	<p>Nurse aide 2 was re-educated on appropriate practices for wearing gloves, changing gloves at appropriate times, hand washing and hand hygiene, and perform hand washing and/or hand hygiene during resident care and a competency completed. Resident 73 had no ill effects.</p> <p>Facility staff will complete training regarding appropriate practices for wearing gloves, changing gloves at appropriate times, hand washing and hand hygiene, and perform hand washing and/or hand hygiene during resident care.</p> <p>Director of Nursing /designee will complete random audits weekly x 4 weeks and monthly x 2 months to verify that staff members are wearing gloves, changing gloves at appropriate times, and following infection control procedures for hand washing and hand hygiene. Ad hoc education to staff who do not perform hand hygiene at appropriate times.</p> <p>Results of audit findings will be reported to the Quality Assurance Performance Improvement Committee.</p>	<p>Completion Date: <b>06/07/2023</b> Status: <b>APPROVED</b> Date: <b>05/08/2023</b></p>	

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F 0880  SS=D	Continued from page 39  including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.  §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.  §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.  §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.  This REQUIREMENT is not met as evidenced by:	F 0880			

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F 0880  SS=D	Continued from page 40  	F 0880			
F 0883  SS=D		F 0883			

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F 0883  SS=D	Continued from page 41  483.80(d)(1)(2) Influenza and Pneumococcal Immunizations  §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.  §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;	F 0883	Resident 53 immunizations reviewed with physician. Pneumococcal Vaccine offered and given to resident. Residents 61 and 65 were reviewed with physician in regards to influenza vaccine for the previous season with no new recommendations. Resident 100 was reviewed with physician regarding not receiving influenza and pneumococcal vaccines. Resident was offered pneumococcal vaccine. Director of Nursing /designee will complete an audit of admissions for the past 30 days for pneumococcal vaccination status and documentation. Any resident identified with wanting pneumococcal vaccine will be offered and provided. Director of Nursing/designee will re-educate licensed nurses on facility policies for Seasonal Influenza Immunization Program and Pneumovax Immunization and documentation of the administration being completed. Director of Nursing / designee will	Completion Date: <b>06/07/2023</b> Status: <b>APPROVED</b> Date: <b>05/08/2023</b>	

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F 0883  SS=D	Continued from page 42  (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.  This REQUIREMENT is not met as evidenced by:	F 0883	audit immunization status of new admission weekly x 4 weeks and monthly x 2. Findings to be reported monthly to Quality Assurance Performance Improvement Committee for further recommendations x 2 months.		

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F 0883  SS=D	Continued from page 43  Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that each resident was assessed, offered and/or received the influenza and/or the pneumococcal immunizations for four of 42 residents reviewed (Residents 53, 61, 65, 100).  Findings include:  The facility's policy regarding Seasonal Influenza Immunization Program, dated April 11, 2022, revealed that annually, prior to the seasonal influenza season, typically in August and September, residents and families/responsible parties are provided current education information provided by the CDC. Consent for vaccine administration will accompany this education. Once the consent is received and a physician's order is obtained, the vaccine is administered. Documentation of the administration will be completed in the resident Medication Administration Record (MAR) /Immunizations.	F 0883			

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F 0883  SS=D	Continued from page 44  Consents returned with a choice made to decline the vaccine for purposes other than allergy, physician contraindication, or religious beliefs will be followed up by the infection control nurse. The nurse will attempt to identify other possible reasons for declination and provide additional education to provide support and attempt to obtain consent. Additional education and outcome will be documented in the resident's clinical record. Residents admitted into the facility during the seasonal influenza season will be offered a vaccine at the time of admission and will be vaccinated as soon as possible. Should the resident decline the vaccine, additional education will be provided and steps followed as stated above.  The facility's policy regarding Pneumovax Immunization, dated April 11, 2022, revealed that upon admission residents would be assessed for eligibility to receive the pneumococcal vaccine series and when indicated would be offered the vaccine unless medically contraindicated or the resident had already been vaccinated. Before receiving a	F 0883			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395830</b>	(X2) MULTIPLE CONSTRUCTION:  A. BLDG: <u>00</u> B. WING: _____		(X3) DATE SURVEY COMPLETED:  <b>04/13/2023</b>
NAME OF PROVIDER OR SUPPLIER: <b>MEADOW VIEW NURSING CENTER</b>  STATE LICENSE NUMBER: <b>191702</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>1404 HAY STREET BERLIN, PA 15530</b>			
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F 0883  SS=D	Continued from page 45  pneumococcal vaccine, the resident or resident representative would receive information and education regarding the benefits and potential side effects of the pneumococcal vaccine. Provision of such education would be documented in the resident's medical record. Residents/resident representatives have the right to refuse vaccination. If refused, appropriate entries will be documented in each resident's medical record indicating the date of the refusal of the pneumococcal vaccine.  A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 53, dated January 24, 2023, indicated that the resident was admitted September 30, 2022, was understood and could understand, required limited assistance from staff for daily care needs, and had diagnoses that included Parkinson's disease. Section O0250 A (Influenza Vaccination) revealed that the resident did not receive the influenza vaccine in this facility for this year's influenza vaccination season. Section O0300 B (Pneumococcal Vaccination) revealed that the	F 0883			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395830</b>	(X2) MULTIPLE CONSTRUCTION:  A. BLDG: <u>00</u> B. WING: _____		(X3) DATE SURVEY COMPLETED:  <b>04/13/2023</b>
NAME OF PROVIDER OR SUPPLIER: <b>MEADOW VIEW NURSING CENTER</b>  STATE LICENSE NUMBER: <b>191702</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>1404 HAY STREET BERLIN, PA 15530</b>			
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F 0883  SS=D	<p>Continued from page 46</p> <p>resident was not up to date on the pneumococcal vaccine.</p> <p>Review of the Immunization Records and nursing notes for Resident 53 revealed no documented evidence as of April 13, 2023, that the resident was offered or received the influenza vaccine during the previous influenza season or the pneumococcal vaccine.</p> <p>A quarterly MDS assessment for Resident 61, dated March 27, 2023, indicated that the resident was admitted on April 29, 2022, was understood and could understand, was dependent on staff for personal hygiene tasks, and had diagnoses that included colon cancer. Section O0250 A (Influenza Vaccination) revealed that the resident did not receive the influenza vaccine in this facility for this year's influenza vaccination season.</p> <p>Review of the Immunization Records and nursing notes for Resident 61 revealed no documented evidence as of April 13, 2023, that the resident was</p>	F 0883			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395830</b>	(X2) MULTIPLE CONSTRUCTION:  A. BLDG: <u>00</u> B. WING: _____		(X3) DATE SURVEY COMPLETED:  <b>04/13/2023</b>
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F 0883  SS=D	<p>Continued from page 47</p> <p>offered or received the influenza vaccine during the previous influenza season.</p> <p>A quarterly MDS assessment for Resident 65, dated January 31, 2023, indicated that the resident was admitted on December 29, 2021, was understood and could understand, required extensive assistance for daily care needs, and had diagnoses that included kidney disease. Section O0250 A (Influenza Vaccination) revealed that the resident did not receive the influenza vaccine because it was offered and declined.</p> <p>Review of the Immunization Records and nursing notes for Resident 65 revealed that the resident refused the influenza vaccine for the 2021/2022 influenza season; however, there was no documented evidence that he was offered education and the influenza vaccine for the 2022/2023 influenza vaccine season.</p> <p>A quarterly MDS assessment for Resident 100, dated March 3, 2023, indicated that the resident</p>	F 0883			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395830</b>	(X2) MULTIPLE CONSTRUCTION:  A. BLDG: <u>00</u> B. WING: _____		(X3) DATE SURVEY COMPLETED:  <b>04/13/2023</b>
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F 0883  SS=D	Continued from page 48  was admitted on November 25, 2022, was sometimes understood and could sometimes understand, required supervision for daily care needs, and had diagnoses that included stroke. Section O0250 A (Influenza Vaccination) revealed that the resident did not receive the influenza vaccine in this facility for this year's influenza vaccination season. Section O0300 B (Pneumococcal Vaccination) revealed that the resident was not up to date on the pneumococcal vaccine.  Review of the Immunization Records and nursing notes for Resident 100 revealed no documented evidence as of April 13, 2023, that the resident was offered or received the influenza vaccine during the previous influenza season or the pneumococcal vaccine.  Interview with the Director of Nursing, who is also the Infection Preventionist, on April 14, 2023, at 10:43 a.m. confirmed that Residents 53, 61, 65, and 100 were residents during the most recent influenza season and that there was no documentation that	F 0883			

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F 0883  SS=D	Continued from page 49  they were offered the influenza vaccine at that time. The Director of Nursing also confirmed that there was no documentation as of April 13, 2023, that Residents 53 and 100 were offered the pneumococcal vaccine.  28 Pa. Code 201.14(a) Responsibility of licensee.  28 Pa. Code 201.18(b)(1) Management.  28 Pa. Code 211.12(d)(1)(5) Nursing services.	F 0883			



# Certified End Page

**MEADOW VIEW NURSING CENTER**

**STATE LICENSE NUMBER: 191702**

**SURVEY EXIT DATE: 04/13/2023**

**I Certify This Document to be a True and Correct Statement of Deficiencies and  
Approved Facility Plan of Correction for the Above-Identified Facility Survey**

A handwritten signature in black ink that reads "Jeane Parisi".

*Jeane Parisi*  
*Deputy Secretary for Quality Assurance*

A handwritten signature in black ink that reads "Debra L. Bogen MD".

*Debra L. Bogen, MD, FAAP*  
*Acting Secretary of Health*



THIS IS A CERTIFICATION PAGE

**PLEASE DO NOT DETACH**

THIS PAGE IS NOW PART OF THIS SURVEY